MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

Testimony on HB 390
Before the Senate Business, Labor and Economic Affairs Committee
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HB 390 proposes to lower state license standards for birth centers operated by nurse midwives. MHA opposes HB 390. We do so for several reasons: Economics, Facility Standards, Patient Safety and Liability.

Nurse Midwife Practice

- Nurse Midwives have been allowed to practice in Montana without physician supervision for more than 20 years. HB 390 does not change that fact.
- Montana Medicaid does not pay for home deliveries except on an emergency basis.
- Nurse midwives approached the Department for facility licensure in order to create a basis for Medicaid and other third party insurance payers. Medicaid granted that request and provided licensure as an outpatient clinic for primary care.
- Outpatient clinic for primary care requires physician direction, a component that midwives found acceptable a little more than a year ago.
- HB 390 seeks to lower standards in order to make access to insurance payments easier to achieve. HB 390 does not lower health care costs. HB 390 increases health care spending.

Facility Standards

- Montana requires an outpatient clinic for primary care to have physician direction. That requirement exists to provide to the public a sense that when Montana issues a license to a health care facility there is official endorsement of the safety and reliability for the public.
- Nurse midwives are able to obtain a license for a birth center under current Montana law, as an outpatient center for primary care. Current standards for a birth center require physician direction.
- HB 390 proposes to better iterate the requirements for a birth center. MHA supports this part of the bill. We agree that current law might be too vague for the purpose of a birth center. But we absolutely oppose ending physician involvement merely to make getting a license easier, rather than as a determination by the state that physician involvement in unnecessary.
- What do other states require? Illinois, California, Oklahoma, Florida, Massachusetts all require physician direction of a birth center. We didn't find a state that didn't!

Patient Safety

- Midwives and physicians disagree about how to identify a low risk delivery. This is a key issue since midwives are only allowed to provide delivery services to low risk patients. By getting rid of the physician, the nurse midwife alone determines what is "low-risk" and what is not.

- Midwives argue that they only provide care within their scope of practice. This means nothing because whenever a complication arises with a delivery the midwife dumps the mother and unborn child onto the nearest hospital emergency room. MHA believes this is poor care.
- When a complication occurs the patient is transported to the nearest hospital. When the mother or baby's life or well-being is at risk, the time required to provide emergency care is critical. The hospital must, according to federal law, provide emergency care within its capacity. That means calling in a physician, anesthesiologist and perhaps a pediatrician within a moments notice to render emergency care. It is not quality care for a doctor to meet a patient for the first time moments before performing surgery when those activities could be accomplished within the preceding 9 months. It is not quality health care to dump your patients unannounced on the hospital by means of a 9-1-1 call.

Liability

- Hospitals and physicians bear the liability and exposure to lawsuits by having to treat nurse midwives' complications. HB 390 does nothing to address this issue. In fact, HB 390 worsens the problem.
- Hospitals and their physicians do get sued by families angered by poor outcomes. MHA asks for your support for amendments that require that birth centers obtain adequate liability insurance and that the centers be required to indemnify and hold harmless hospitals and physicians that provide emergency care to birth center patients.

Other Issues

- HB 390 should have a fiscal note. While the DPHHS license staff has said they don't see a big financial impact, Medicaid will. There will be a lot more birth centers when the state lowers its standards. Medicaid covers 40% of Montana births, and will begin to make added payments for babies delivered in birth centers.
- Montana insurance statutes currently include a mandated benefit of a 2-day stay for new mothers and their babies. This statute was enacted in response to the concern that new mothers were being forced out of licensed health facility too soon. Montana now proposes to limit the stay at a birth center to less than 24 hours. HB 390 should be amended to eliminate this conflict in the law.
- There are several important amendments sought by the Department of Public Health and Human Services, and supported by Rep. Reinhart. MHA supports most of the amendments. In particular, we support the amendment that requires a birth center to notify a hospital prior to making a transfer, and providing pertinent medical records with the patient. A formal transfer agreement would be preferable.

MHA urges this committee to oppose HB 390.

The HB 390, a bill that would provide for the licensing of outpatient birth centers, is set for hearing in the Senate Business, Labor & Economic Affairs Committee on Friday the 13th of March.

As providers of Regional High Risk Perinatal, Obstetrical and Level III Neonatal care (NICU), we are the recipients of mothers and infants arriving at our doors when a birthing center or home delivery is unsuccessful. By the time these patients arrive, we are not always able to prevent the long term devastating effects of hypoxia, or birth trauma.

Recently our medical center has experienced three such cases of mothers attempting a vaginal delivery after a previous cesarean birth (VBAC) at home or in a birthing center while under the supervision of a midlevel. Two of these cases resulted in resuscitation of the newborn after the emergency cesarean section. Each of these deliveries resulted in extended stays in the NICU at a cost of hundreds of thousands of State, Medicaid dollars.
On of the cases is described below.

This case was a home delivery with a mid-level assisting. The father stated that the mother's pelvic bone was broken by the Midwife to accommodate the delivery of a large infant. Due to size, the infant would not progress into the vaginal canal. The infant had been stuck for some time. The infant was delivered floppy and blue, requiring resuscitation. The mid-level began giving oxygen, per the parent's recollection. The mid-level had the father drive and placed the mother and infant in the car. Sitting in the back of the car with the mother, the midlevel vigorously stimulated the infant and gave oxygen until it ran out and then resorted to rubbing the back and shaking of the infant (the infant had significant bruising as a result). The midlevel called for an ambulance who met them on the road which took the infant to the closest hospital's Emergency Department. A call was then placed to our hospital's NICU transport team by the referring hospital's ER for transport to our NICU. Upon arrival, it was noted that the infant had sustained multiple injuries including bilateral cephlahematomas, subdural hematoma, seizure activity, poor tone and poor suck /swallow reflexes - suggesting irreversible neurological injuries.

Upon arrival, the frightened and exhausted mother will understandably look to the hospital to save her and her infant. However several days later, we are often dealing with anger as these families begin the grieving process. Their realization, that their dream of normal parenting is gone when the team is unable to give the prognosis expected. Typically, the blame game then begins; was it due to the delay in treatment, was it due to a delay in transport, or was it due to a delay in getting a physician? Then the question; who is the responsible party in this case, is it the parents, the midlevel or the hospital? Someone must be held accountable for the less than perfect child.

The ability to always predict a "low risk delivery" is impossible. No one can say that there will not be an umbilical cord with a "true knot" in it (caused from a normal active infant twisting in utero), or a nucal cord (the umbilical cord is wrapped around the neck one or more times). In both of these cases the oxygen is cut off from the infant as the infant descends the vaginal canal. At times an immediate c-section is needed to save the life of the child – a service that is not readily available in a home or birthing center.

All infants should receive the best possible chance at a productive life. We ask for protections to be in place for the rights of infants. We also ask for protection for the hospitals, staff and physicians that are left to managing, financing, and dealing with outcomes that are the result of poorly coordinated care.